

Topic 6: *Depression/Delirium/ Dementia in Older Adults*

Competencies

1. Describe the prevalence of depression in older adults.
2. Discuss symptoms and treatment strategies for depression in older adults.
3. Use an assessment instrument for depression in older adults (see Topic 5).
4. Describe the prevalence of delirium and dementia in older adults.
5. Discuss the symptoms of delirium and dementia.
6. Discuss the assessment and treatment strategies for delirium and dementia.
7. Contrast criteria for differentiating depression, delirium, and dementia in older adults.

Note: Depression, Delirium, and dementia are discussed together because in older adults they often mimic each other and can be easily confused.



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Content Outline

1. Describe the prevalence of depression in older adults.

Depression is defined as a clinical syndrome characterized by lower mood tone, difficulty thinking, and somatic changes precipitated by feelings of loss and/or guilt.

Clinically depressed symptoms range from 8% to 15% among community-dwelling older persons and 30% among institutionalized older persons. The symptoms are often associated with chronic illness and pain.

Major depressive disorders occur less often in older adults compared to younger adults; however, 27% of older adults experience depressive symptoms.

The highest rate of completed suicide of any age, gender, or ethnic group is among older white men. The risk of suicide is higher in older adults than the rate for younger people (up to six times more frequent in older white men over 85 years of age).

Chronic depression in older adults occurs in 7% to 30% of all cases of depression, with a third of those who recover relapsing in the first year.

As younger persons with their higher prevalence of depression age, the incidence of depression in older adults is expected to increase over the next 20 to 30 years.

2. Use an assessment instrument for depression with older adults (see Topic 5).

3. Discuss symptoms and treatment strategies for depression in older adults.



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A. *Clinical manifestations of depression in older adults:**

1. *Mood:*

Depressed, irritable, or anxious (may deny sad mood and complain of pain or somatic distress).

Crying spells (or complaining of inability to cry or experience emotion).

Persistent >14 days.

2. *Associated psychological symptoms:*

Reduction in gratification, loss of interest in usual activities, loss of attachments, social withdrawal.

Lack of self-confidence, low self-esteem, self-reproach.

Poor concentration and memory.

Negative expectations, hopelessness, helplessness, increased dependency.

Recurrent thoughts of death.

Suicidal thoughts.

3. *Somatic manifestations:*

Anorexia and weight loss.

Insomnia—early morning awakening.

Psychomotor retardation.

Agitation—common symptom in an older person.

4. *Psychotic symptoms:*

Delusions of worthlessness and sinfulness.

Delusions of ill health.

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Delusions of poverty (Evaluate delusions as 30% of elderly women already are at the poverty level.).

Depressive hallucinations in the auditory, visual, and olfactory spheres (rarely).

B. *Treatment strategies for depression in older adults: Algorithm for depression* (see page 6-5).

C. *Treatment strategies*

1. *Pharmacologic:*

Antidepressants used in primary care for treatment of older persons (with side-effect profiles).

Principle regarding dosages with the elderly: “Start Low Go Slow.”

Carefully monitor for side effects (e.g., falls, anorexia)

Name	Sedation	Excitation	Anticholinergic Effects	GI Upset	Orthostasis
Nortriptyline	X		XX		X
Fluoxetine		XX		X	
Sertaline		X		X	
Paxoxetine		X		X	
Trazodone	XX				X
Venlafaxine				X	
Bupropion		X	X	X	

Ham, R. J., and Sloane, P. D. (1997). *Primary Care Geriatrics: A Case-Based Approach* (3rd ed.). New York: Mosby. Used by permission.

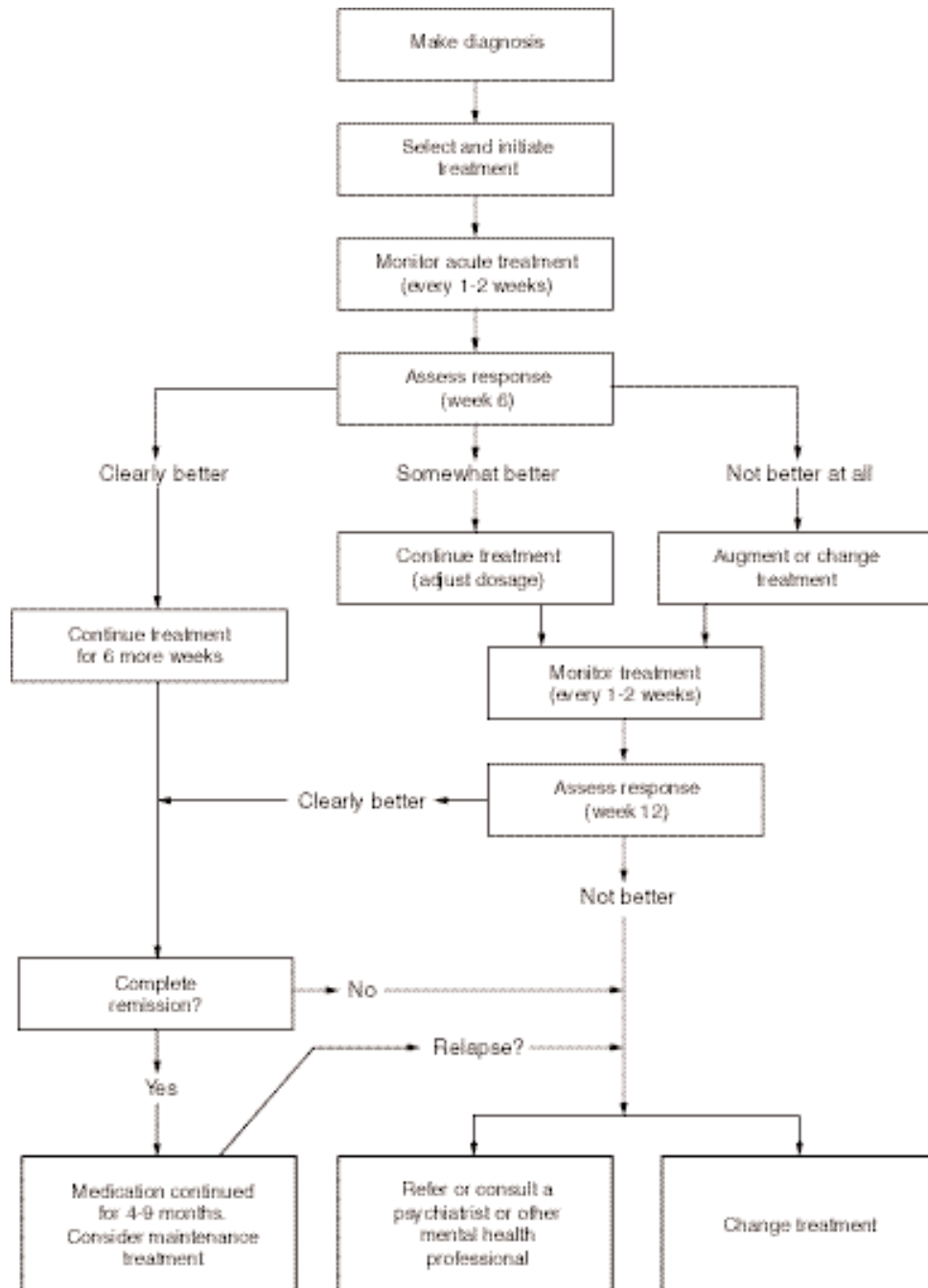
2. *Electroconvulsive therapy:*

Treatment of choice for older persons with severe depression. Improvement rate in older persons who do not respond to antidepressant drugs is 80% (same as younger persons).



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Source: Agency for Health Care Research and Quality (AHRQ) formerly (AHCPR), *Depression in Primary Care*, 1993, Volume 2, p. 29.



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3. *Psychotherapy* (Individual and Group):

Especially effective in preventing relapses of episodic depression (30% relapse rate of depression in older persons).

Consider that older persons may have negative attitudes toward psychotherapy.

4. Describe the prevalence of delirium and dementia in older adults.

Four to five million persons (about 2% of all ages and 15% of those over age 65) are estimated to have cognitive disorders, such as delirium or dementia.

The incidence of cognitive disorders increases with age, especially in adults over 85 years of age.

Delirium or acute confusional states occur in 30% of older persons during medical hospitalization and in 10% to 50% of older people during surgical hospitalization; most at risk are older persons who have fallen and sustained a hip fracture.

Dementia or cognitive impairment occurs in 5% to 15% of older persons, with prevalence rates increasing as age increases; 30% to 50% of persons age 85 and over have dementia.

Alzheimer's disease accounts for 50% to 60% of all dementia in the United States, affecting an estimated 4 million adults over age 65. Other causes of dementia are vascular dementia and Parkinson's disease.



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5. Discuss the symptoms of delirium and dementia.

Delirium is defined as mental disturbances characterized by acute onset, disturbed consciousness, impaired cognition, and an identifiable underlying medical cause (medications, anesthesia, sleep disturbance, electrolyte imbalance, etc.) Delirium is a reversible confusional state.

Dementia is a syndrome of acquired impairment of mental function, not the result of an impaired level of arousal, with compromise in at least three of the following areas of mental activity: (1) language, (2) memory, (3) visuospatial skills, (4) personality or emotional state, and (5) executive function (abstraction, judgment). Dementia is usually an irreversible confusional state.



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Symptoms of Delirium and Dementia

<i>Delirium</i>	<i>Dementia</i>
Abrupt precise onset with identifiable date	Gradual onset that cannot be dated
Acute illness, generally days to weeks, rarely more than 1 month	Chronic illness, characteristically progressing over years. Diagnosis based on at least six months of confusion
Usually reversible, often completely	Generally irreversible, often chronically progressive
Disorientation early	Disorientation later in the illness, often after months or years
Variability from moment to moment, hour to hour, throughout the day	Much more stable day-to-day (unless delirium develops)
Prominent physiological changes	Less prominent physiological changes
Clouded, altered, and changing level of consciousness (alert→lethargy)	Consciousness not clouded until terminal (alert but confused and disoriented)
Strikingly short attention span	Attention span not characteristically reduced
Disturbed sleep-wake cycle with hour-to-hour variation	Disturbed sleep-wake cycle with day-night reversal
Marked psychomotor changes (hyperactive or hypoactive)	Psychomotor changes characteristically late (unless depression develops)

Source: Ham, R. J., and Sloane, P. D. (1997). *Primary Care Geriatrics: A Case-Based Approach* (3rd ed.). New York: Mosby. Used by permission.



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6. Discuss the assessment and treatment strategies for delirium and dementia.

A. *Delirium*

1. Assessment of delirium:

- Comprehensive history and physical examination (there may be more than one problem).
- Review of all current medications.
- Evaluate basic laboratory studies (complete blood count, serum electrolytes and urinalysis).
- Consider further testing on basis of results of laboratory studies and response to initial therapy (chest radiography, cultures, drug levels, serum vitamin B12 and folate levels, thyroid function tests, pulse oximetry, electrocardiogram, brain imaging, lumbar puncture, electroencephalogram).

2. Treatment of delirium:

- Identify and treat the underlying cause.
- Provide supportive and restorative care.
- Treat behavioral symptoms that may result.
- Failure to treat delays recovery and can worsen the older person's health and function.

B. *Dementia*

1. Assessment of Dementia:

- Use a screen for cognitive status in older adults: Folstein MMSE (see Topic 5).



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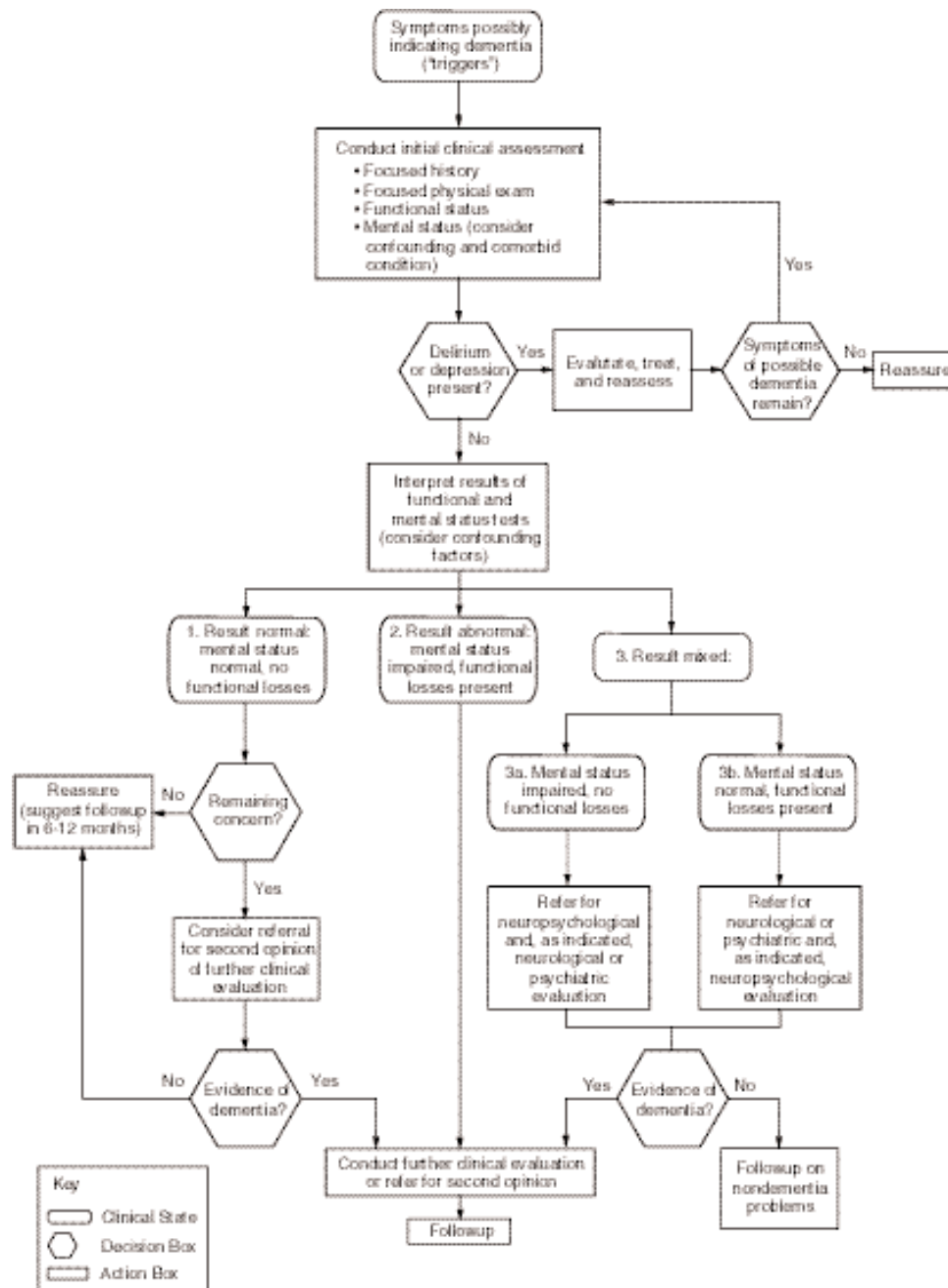
2. Treatment of dementia:

- Alzheimer's disease—Treatment nonspecific (see page 6-11).
- Alzheimer care—Although there are no treatments to reverse the progression of Alzheimer's disease, strategies to support and sustain individuals with the disease exist. The primary objective of care is to help the person use as many retained abilities as possible. Careful attention to factors that create excess disability (more disability than can be attributed to the disease itself) is critically important. Persons with Alzheimer's disease gradually lose their ability to understand our shared reality. As a result, they misinterpret previously understood events and objects in their physical and social environment. Simple adjustments in routine help the person understand, and function at as high a level as possible. The following suggestions from the Alzheimer's Association may help:
 - Use personal history, life experiences, and habits as a basis for self-care and leisure activities. For example, if the individual enjoyed gardening before developing Alzheimer's disease, caregivers can help them participate in gardening activities as they are currently able.
 - Maintain a familiar and comfortable routine that alternates activity with rest to avoid fatigue and dysfunction.
 - Slow down, speak clearly, make eye contact, and stay in the person's field of vision.



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Source: Adapted from materials developed by the Alzheimer's Association.



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- Promote independence by cueing the person to do as much for him or herself as possible.
- Limit choices to ones the individual can make by using close-ended questions. For example, if the individual is confused by dressing independently, the caregiver might choose two outfits and ask the individual to pick between them.
- Modify the physical environment to reduce misinterpretation of real-life object or events.
- Redirect or distract the person who is delusional instead of correcting or confronting him or her.
- Monitor the individual for symptoms of personal distress such as pain, hunger, or over/under stimulation. Pain assessment should be included in the ongoing plan or approach to caregiving. (See Topic 10.)
- Use behavioral symptoms as a source of communication to guide both assessment and intervention. For example, individuals may behave as if they are being violated during a bath because they feel violated. Framing bath time as a spa visit could change the behavior.
- Promote independence, autonomy, and self-directed meaningful activities within a safe, secure setting.

In sum, respect for, and attention to, the person behind the disease provides a basis for thoughtful, person-centered interventions that promote function and well-being.



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3. *Behavioral strategies:* Treatment of choice for behavioral symptoms
 - Reality orientation (in early stages).
 - Validation therapy (in later stages).
 - Structured, routine daily activities.
 - Activity therapies (including intergenerational and pet).
 - Environmental design/modifications for safety.
 - Milieu therapy.
 - Occupational and physical therapy.
 - Prostheses for sensory impairments.
4. *Caregiver support and education:*
 - Strong group referral.
5. *Pharmacologic strategies:*
 - Cognitive medications—treatment of cognitive symptoms such as memory loss and physical aggression:
 - Tacrine
 - Donepezil
 - Stroke prevention (for vascular dementia):
 - Aspirin
 - Ticlopidine
 - Plavix
 - Antipsychotics:
 - Haloperidal (Haldol)
 - Thiordazine (Mellaril)
 - Perphenazine (Trilafon)
 - Risperidone (Risperdal)
 - Olanzapine



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- Benzodiazepine
 - Ativan
- Antidepressants:
 - Nefazodone
 - Nortriptyline
 - Paroxetine
 - Sertaline
 - Trazadone
- Other:
 - Buspirone
 - Divalproex sodium

7. Contrast criteria for differentiating depression, delirium, and dementia in older adults.

Often depression, delirium, and dementia can co-exist so the following protocol should be followed:

- Delirium assessment and treatment 1st
- Depression assessment and treatment 2nd
- Dementia assessment and treatment 3rd



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Instruments/Scales

Differentiation among Depression, Delirium and Dementia*
(also see Topic 5).

Parameter	Depression	Delirium	Dementia
Onset	Weeks	Short/rapid, Abrupt, Hours/days	Months to years
Duration	3 to 6 months, may be chronic	Days to 3 weeks	5 to 15 years
Initial presentation	Flat affect, Hypochondriasis, Focuses on symptoms, Apathy, Little effort to perform tasks	Disorientation, Clouded consciousness, Fluctuating moods, Disordered thoughts, Fails to understand tasks	Vague symptoms, Loss of intellect, Denies/conceals symptoms, Easily distracted, Great effort to perform tasks
Recent memory	Normal or recent/past both altered	Patchy, Remote intact	Impaired, Perseveration, Confabulation
Intellect	Slowed, may be unwilling to respond	Impaired	Impaired, Concrete thinking
Judgment	Poor judgment, Many "don't know" answers	Impaired, Difficulty separating facts & hallucinations	Impaired, Bad/inappropriate decisions, Denies problem
Diurnal Pattern	Worse in morning, Sleep impaired	Day drowsiness, Nighttime hallucinations, Insomnia, Nightmares	Worse in evening, "Sundowning," Reversed sleep
Attention/Affect	Withdrawn, Constricted, Apathy, Hopeless, Distressed	Labile, Variable, Fear/panic, Euphoria, Disturbed	Easily distracted, Shallow, Labile, Inappropriate anxiety, Depression, Suspicious
Orientation	Intact	Disoriented, but usually not to person, Periods of lucidity	Disoriented
Level of consciousness	Intact	Disturbed	Intact
Psychotic symptoms	Delusions	Delusions	Late delusions, Hallucinations

**Health Assessment of the Older Individual*, 2nd Edition. Differentiation Among Depression, Delirium, and Dementia, Mezey, M. Copyright © 1993. Springer Publishing Company, Inc., New York 10012. Used by permission.



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Instruments/Scales

CLINICAL CHARACTERISTICS FOR AGE-ASSOCIATED COGNITIVE DECLINE AND ALZHEIMER'S DISEASE*

Normal Phase (No Cognitive Decline)

- No subjective complaints of memory deficit.
- No memory deficit evident on clinical interview.

Early Confusional Phase (Mild Cognitive Decline)

- Increased forgetfulness.
- Decreased performance in employment and social settings.
- Objective evidence of memory deficit obtained with an intensive interview.
- Mild to moderate anxiety accompanying symptoms.

Early Dementia Phase (Moderately Severe Cognitive Decline)

- Can no longer survive without assistance.
- Cannot recall major relevant aspects of their current lives.
- Some difficulty choosing proper clothing to wear.
- Able to retain knowledge of major facts (name, family's names, etc.).
- May require some assistance with ADL.

Late Dementia Phase (Severe Cognitive Decline)

- No verbal abilities.
- Incontinent of urine.
- Loss of basic psychomotor skills.
- Requires assistance toileting and feeding.

*The Global Deterioration Scale for assessment of primary degenerative dementia. American Journal of Psychiatry, 139, 1136–1139, 1982. Copyright 1982, the American Psychiatric Association. Reprinted by permission.



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Case Studies

A. Case Study: *Depression*

Ms. G is a 75-year-old female living alone in her apartment in New York City. Her husband died suddenly two years ago of a heart attack. Their two children are alive and living out-of-state. Both of her sons maintain weekly phone contact with Ms. G and visit usually once a year. Ms. G has been doing well until about 6 weeks ago when she fell in her apartment and sustained bruises but did not require a hospital visit. Since then she has been preoccupied with her failing eyesight and decreased ambulation. She does not go shopping as often, stating she doesn't enjoy going out anymore and feels "very sad and teary." Ms. G states that her shopping needs are less, since she is not as hungry as she used to be and "besides I'm getting too old to cook for one person only."

B. Case Study: *Delirium*

Mr. T is a 70-year-old male admitted to the orthopedic unit in a large urban hospital. Mr. T fractured his right ankle in a golf outing and had an open reduction with internal fixation this morning. As you take report at 3 PM, the day-shift charge nurse tells you that Mr. T is insisting on going home and keeps getting out of bed. Multiple attempts to explain that he is unable to walk safely in the cast have not convinced him and he is now yelling, disturbing other patients on the floor.

C. Case Study: *Dementia*

Ms. D is a 98-year-old female in a skilled nursing facility with a diagnosis of Alzheimer's disease. Ms. D comes to the nursing station and appears very upset. She tells you that she is looking for her mother and asks you to help her. You start walking with Ms. D Which of the following strategies would be helpful in assisting Ms. D?



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Evaluation Strategies

Evaluation of Case A: Depression

What risk factors might account for Ms. G's symptoms of depression?

Answer: Living alone, minimal social support, advancing age, pain, loss of independence, and loss of spouse.

What are Ms. G's depressive symptoms?

Answer: Sustained sad mood (>14 days), lack of enjoyment in previously pleasurable activities (going out), social isolation, decreased nutritional intake, expressions of self-negation ("I'm getting too old").

What might be some treatment strategies for Mrs. G?

Answer: Pharmacologic, family involvement (might increase visits and/or phone contacts), friendly visitor contacts (community or religious groups), home-delivered meals, psychotherapy (at clinic with transport or home).

Evaluation of Case B: Delirium

Given the above information, you suspect that Mr. T's condition is caused by:

- (a) Post-operative infection
- (b) Dementia
- * (c) Delirium
- (d) Depression

Delirium:

- (a) Is self-limiting and requires no intervention
- (b) Usually has no identifiable cause
- * (c) Requires acute assessment
- (d) Should be treated symptomatically



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Evaluation Strategies

The causes of delirium include:

- (a) Infection
- (b) Hypoxia
- (c) Medications
- * (d) All of the above

Some strategies to assist in caring for Mr. T would include:

- (a) Reality orientation offered in a calm, nonjudgmental manner
- (b) Calling family to visit patient
- (c) Telling him to relax and his ankle will heal
- * (d) a and b only

Evaluation of Case C: Dementia

True or False:

- | | |
|--------------|---|
| <i>False</i> | Telling her that her mother died a long time ago. |
| <i>True</i> | Reassuring her that everything is okay and that you will help her. |
| <i>True</i> | Attempting to distract/redirect her into a pleasurable activity (eating, singing). |
| <i>False</i> | Using reality orientation hoping to reverse her cognitive losses. |
| <i>True</i> | Asking her to help you with a small task and later you will look for her mother together. |
| <i>True</i> | Cognitive losses related to Alzheimer's disease are irreversible. |



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Evaluation Strategies

- True* Although pharmacologic agents may be helpful (in the presence of disturbing delusions/hallucinations), behavioral approaches to treatment are first-line in treating dementia.
- False* Promoting dependence (with feeding, dressing, toileting) is advantageous for persons with dementia.
- True* Compensating for sensory impairments (glasses, hearing aides) may help minimize disturbing illusions/delusions.

Source: The material on pages 6-17 through 6-20 is adapted from *The Merck Manual of Geriatrics*, 3rd ed., edited by M. H. Beers and R. Berkow. copyright 2000 by Merck & Co., Inc., Whitehouse Station, NJ.



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Experiential Activities/ Clinical Experiences

- A. Use case studies.
- B. Visit an Alzheimer's day-care center.
- C. Volunteer as a friendly visitor to sit with an elderly confused adult in a hospital or nursing home.
- D. Attend an Alzheimer's Association support group.



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Resources

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Other Resources

Alzheimer's Disease and Related Disorders Association (ADRDA): Have local chapters and assist in family caregiving, support groups, and so on.

Aging & Dementia Centers: Federally funded centers for assessment and treatment of dementia.

Alzheimer's Disease Education and Referral (ADEAR) Center
www.alzheimers.org/adear

Alzheimer Research Forum Page
alzforum.org/members/index.html



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Resources

National Institute of Mental Health (NIMH)
www.nimh.nih.gov

National Institute of Neurological Disorders and Stroke
www.ninds.nih.gov

National Parkinson Foundation
www.parkinson.org

